



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

KENNETH A MARTIN MD
NUMBER 5 SAINT VINCENT CIRCLE SUITE 100
LITTLEROCK AR 72205

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-06-3085-01

MFDR Date Received

January 4, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Surgery originally scheduled for 08-11-2005 & authorized under EPG072115P was re-scheduled to 09-13-2005. On 08-26-05 Regina in our precert dept. called and left a voice mail on 800-859-5995 x 4716 to change date of service but she did not check back to see if approved. Claim denied. Betty Young 12-20-05."

Amount in Dispute: \$4,706.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The timeframe, as indicated on the preauthorization letter was for services to be DONE on 8/11/05. If a change in facility is necessary, please contact the preauthorization department prior to completion of services. Treatment or procedure(s) to be completed with agreed upon period of time. The requestor provided no explanation for providing the services outside the specified preauthorized time period of, one month after the approved date of 8/11/05. There is no record on file that the requestor notified the preauthorization department to inform them of the change in time-frame."

Response Submitted by: TEXAS MUTUAL INSURANCE COMPANY

SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|--------------------|------------------------------|-------------------|------------|
| September 13, 2005 | Shoulder arthroscopy/surgery | \$4,706.00 | \$0.00 |

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600 (n), effective date of this section is March 15, 2004. Requests for preauthorization submitted prior to March 15, 2004 shall be subject to the rule in effect at the time the request was submitted.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated October 25, 2005

- Note: Pre-auth for date of service 8/11/05. No extension requested
- CAC-B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service
- CAC-62 – Payment denied/reduced for absence of, or exceeded, pre-certification/authorization
- 287 – This service is denied because the doctor is not on the Texas approved doctors list (ADL) for this date of service
- 930 – Pre-authorization required, reimbursement denied.

Issues

1. Did the requestor render the services outside the preauthorized timeframe?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.600(e)(2)(B) states “The requestor or employee shall request and obtain preauthorization from the carrier prior to providing or receiving health care listed in subsection (h) of this section. Concurrent review shall be requested prior to the conclusion of the specific number of treatments or period of time preauthorized and approval must be obtained prior to extending the health care listed in subsection (i) of this section. The request shall: (2) include: (B) the number of specific health care treatments and the specific period of time requested to complete the treatments.”
 - Review of the preauthorization letter (#EPG072115P), dated July 22, 2005 reviewed that the insurance carrier authorized a surgical procedure of right shoulder arthroscopy with acromioplasty to be done 08/11/05, by Arkansas Surgical Hospital.
2. The requestor rendered and billed for the surgery performed on September 13, 2005. The service was rendered outside the approval date and outside of the pre-authorized timeframe. Therefore, per 28 Texas Administrative Code §134.600 (e), reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

| | | |
|-----------|--|-------------------|
| _____ | _____ | February 15, 2013 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.